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County Health and Federal Reform – What's Next?

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"If you don't know where you're going, any road will take you there." George Harrison
http://www.youtube.com/watch?v=mePp1l299EE

Counties play three important health roles today: first, they deliver or pay for care to the low income uninsured; second, they enroll low income individuals in Medi-Cal; and third, they operate public health programs for all county residents.

What are their future roles? Their provider/payor-of-last-resort role for the uninsured will greatly diminish and potentially disappear in many California counties, although county hospitals and clinics will endure with potential changes in their governance. Their enrollment role could be vastly simplified, with it being passed to the state and/or remaining at the county level. Counties will coordinate and assist with needed outreach, education and communication. The counties' public health role might shift quite dramatically and coordinate better with local community based organizations, managed care and employer plans and become the most important of the three county health functions.

We think it useful to discuss these evolutions now so they can be thoughtfully discussed and planned.

County roles in care and coverage of the uninsured

In the payor counties such as Orange and San Diego, the county role in paying for care to the uninsured is likely to disappear entirely. Counties will need to decide where to reinvest their current spending and may face state efforts to recapture the "savings" from federal takeover of the costs of care for medically indigent adults (MIA). Similarly, in the 34 small CMSP counties, the county role in paying for care to the uninsured will also disappear, and will face comparable challenges to the larger payor counties.

Where might these counties reinvest their "savings"? It could be in dental care for adults, targeted rate increases for certain specialties where there is poor access, a major focus on prevention, investments in the needed infrastructure such as primary care practitioners or chronic disease case management, and/or care for the residually uninsured. It could be budget balancing for the state or county government.

In the hybrid counties like Tulare, Santa Barbara, Stanislaus and Sacramento, the county role in paying for hospital care to the uninsured will disappear and be taken over by Medi-Cal and the Exchange. Hybrid counties operate their own county clinics, and there will be a large increased need for primary care under federal reform. These county clinics are in a strong position to meet this need, but not before making significant changes. The clinics will be compensated for many of their existing uninsured patients through Medi-Cal or Exchange-participating health plans. County clinics will need to participate effectively in these plans, which will require reorientation of their clinical practices to comply with the quality, patient outcomes, timely access and efficiency norms of managed care. They will need to be or to become competitive with the private sector for their patients' loyalty in a new market where patients will have a far broader choice of plans and providers. They will need to shift from episodic care for an ever-shifting population to care management for a defined enrolled population. Clinics in these hybrid

counties will need to coordinate with private hospitals and specialists, possibly forming ACOs (accountable care organizations). County policy makers may need to decide whether their county clinics should specialize in primary or specialty care. They will need to decide whether to maintain their public status or become a non-profit community clinic. Community clinics may be better positioned for federal grants and contracts under the §330 programs, as well as better reimbursement under Medi-Cal and the Exchanges. They will need to adopt electronic health records (EHR) technology, master its use, and promote its prompt deployment. Lastly, those county clinics that care for the undocumented will need to decide how to finance this care, and whether to integrate these services with their delivery model for the insured population or to continue to maintain a separate episodic model of care for the undocumented. Some hybrid counties, such as Santa Barbara and Santa Cruz, are also COHS (County Organized Health System) managed care counties, and the county clinics will need a strong affiliation/partnership with their local safety net managed care organizations (MCO). To the extent that this partnership proves successful, the county may want to transfer or share ownership and governance of its clinics with the COHS; this would allow for greater alignment of priorities and afford the local clinics and COHS some of the same efficiencies as integrated health plans such as Kaiser Permanente enjoy.

Provider or public hospital counties face the greatest challenges and opportunities. Most of their current uninsured patients will have coverage through the Exchange and Medi-Cal; many other uninsured patients will be newly insured and might choose care from county providers. County hospitals have many competitive advantages in attracting and retaining the newly insured, including language, culture, location, attractive new facilities and patient familiarity. Some have real weaknesses as well: inadequate investment in primary care, long waits for care, slow response to changing environments, poor governance, inadequate health IT and poor data systems, inadequate quality controls, insufficient focus on patient outcomes, weak relations with MCOs and the lack of public-private partnerships.

Some have been incredible pioneers in adopting and embracing change while others have lagged considerably. Some could become integrated delivery networks and/or form ACOs. This will require development of strong partnerships with local MCOs and local private partners, such as clinics, doctors and hospitals.

Like clinics in the hybrid counties, facilities in provider counties may want to develop shared governance with local MCOs. Others could and should become stand-alone facilities with innovative, expert, local or regional governance and the ability to contract swiftly with large commercial and local public MCOs for the services where they have demonstrated competence and expertise. Civil service rules, local politics and county bureaucracies are likely to hinder the rapid evolution necessary; this must change and may require governance restructuring as Alameda undertook several years ago.

Public hospitals and hospital emergency rooms will remain an important resource in caring for the undocumented, but it is unclear how many undocumented receive care in which county facilities, as well as the type of care they receive. What we do know is that roughly one fifth of the uninsured are undocumented and they use much less services than do US citizens and legal permanent residents. We also know their use of care is primarily for emergency and maternity services. Medi-Cal pays for genuine emergencies, prenatal care and deliveries for undocumented workers and their families, but for very little else. The Exchange will offer no coverage at all for the undocumented. DSH funds do help pay for some uncompensated hospital care, but they will eventually be reduced as more of the uninsured are covered. Such funds should be

redistributed to those with the heaviest burdens of uncompensated care to the residual uninsured.

Some counties may have over-loaded their systems with high administrative costs, which must be offloaded by 2014 so that county facilities are competitive. Others have hospital-centric systems with a heavy reliance on academic medicine and their future will be tied to the evolution in academic medicine.

By 2014, the locus of control and financing for care to the MIAs will shift from the county to the federal and state governments and to the commercial/local MCOs that will cover the MIAs. This requires a very rapid pivot for all who are concerned with care for the MIAs. The scarcest and most valued resource will be primary care; another highly valued asset will be the ability to manage care and costs for the chronically ill. An asset that may/should see lower use is the county hospital emergency room. This is a 180-degree shift in delivery system priorities for some county safety nets.

Mental health
During the '90s, mental health and county indigent health got a divorce, driven in part by financial difficulties because mental health was constantly on the losing end of county and state budget allocation wars. Beginning in 2014, mental health will be part of the minimum benefits covered by MCOs in the Exchange and federal Medicaid expansion with 100% federal funding. Coverage of mental health for the uninsured will constitute a large savings to California's state and county governments, albeit difficult to quantify because county mental health programs do not report their expenditures on the uninsured to state government.

Patients are not being well served by separated local systems that do not communicate or coordinate their care and treatment. Successful mental health and substance abuse treatments markedly reduce the need for physical health services and will become an important component of MCOs. State and county decision makers will need to reintegrate the separate delivery systems, and their delivery of care and finances will eventually be coordinated within MCOs and ACOs.

Application, enrollment and eligibility systems

Enrollment in the Exchange and Medi-Cal will be transformed just as completely from a culture that encourages administrative obstacles and delays to a culture that facilitates and rewards speedy enrollment.

To completely understate the obvious, current Medicaid eligibility rules are complex, but they can and will be drastically simplified as part of the reform process. The Exchange income eligibility rules are quite simple: does your modified adjusted gross income as reported on your federal taxes fall between 133 and 400% of FPL? There is no assets test for the Exchange. There is no Exchange eligibility for the undocumented, but all US citizens and legal permanent residents (LPR) are eligible in the Exchange.

Medi-Cal eligibility can be simplified so that is only slightly more complex than the Exchange. For example, Medi-Cal must cover all US citizens and LPRs with adjusted gross incomes up to 133% of FPL for a standard scope of benefits; it must eliminate the assets test and it must use adjusted gross income as the Exchange does. Medi-Cal covers the undocumented for a very limited scope of emergency and perinatal services. The added complexities for Medi-Cal are the different matching rates among categories of eligibles, such that the MIAs and newly eligible

parents (100-133% of FPL) will have 100% of federal match, while the other categories will have the traditional 50/50 (currently 62/38) match. In addition, Medi-Cal must retain its old rules for determining residual categorical populations, such as TANF, SSI, long term care, the elderly and disabled.

For both Medi-Cal and the Exchange, there is a need to cross check for employment-based coverage to determine whether the employer's plan is primarily responsible for the employee's coverage. For both programs, immigration status and citizenship need to be assessed.

Some of the tough issues are 1) switching from the Medi-Cal income counting rules and 2) consolidating Medi-Cal's mini-programs into the Exchange. What does this mean? Medi-Cal has a well-developed yet complicated set of income disregards and income deductions; they are deeply rooted in the welfare program rules that preceded and undergird the Medi-Cal eligibility rules, and they are completely at variance with the very simple "modified adjusted gross income" test of the Exchange. In the event of a switch to adjusted gross income, some Medi-Cal eligibles will move into the Exchange where they have a broader choice of plans and providers, but must contribute more for their care and coverage in the form of premiums, copays and deductibles. It may be essential to retain the "actually available income" test so that the prior year's income is not imputed to an individual or family whose income has precipitously dropped.

Important mini programs, such as coverage for pregnancies, breast cancer, family planning and AIDS drug treatments, extend above 133% of FPL and cover uninsured individuals up to 200% of FPL. These services will be covered in the Exchange, and California will have strong financial incentives to assure that most program eligibles switch into the Exchange, where the federal government pays 100% of the subsidy. The same financial incentives for the state to merge programs into the Exchange apply to the medically needy and share-of-cost programs that pay for catastrophic medical expenses primarily in hospital settings. It is unclear how far California will or should go in rolling the mini programs into the Exchange for several reasons: first, the mini programs serve as a limited safety net for the undocumented and for those who, for a variety of reasons, do not enroll in the Exchange; and second, they have unique and important design features at variance with traditional commercial coverage product designs offered in the Exchange, such as the excellent privacy features preserving the confidentiality of family planning services or the nutritional, counseling and health educational services offered to pregnant women in the Comprehensive Perinatal Services Program.

In an ideal system, the state, not the counties, would determine eligibility respectively for Medi-Cal, Healthy Families and the Exchange, and issue appropriate ID cards. There would be no ping ponging of program eligibles; rather they would switch seamlessly between programs as their income eligibility shifts. Counties, providers, plans, brokers, CAAs and CBOs would be responsible for outreach and application assistance. Applications could be submitted in multiple venues from schools and workplaces, to provider offices and public agencies via mail, fax or the Internet. Computer crosschecks would be used to verify an applicant's eligibility with individual intervention and assistance from local sources, where needed. We might deputize certain trustworthy local institutions to preliminarily determine eligibility in medical emergencies and for urgent care.

Is such a system possible? Yes, but only if we are ready to engage in a deliberative process on these issues, and decisively break from the "can't be done" mentality that too often hampers serious discussions.

County public health programs

Counties operate public health programs for all county residents regardless of income and immigration status. Some public health programs are directed to track and prevent the spread of infectious disease, some to encourage healthier behaviors. Some public health programs readily interface with care for the newly insured under the federal reforms, such as immunizations, preventive services and health education. Others will have tangential impacts, such as campaigns to reduce smoking or obesity, and to promote healthy eating and behaviors.

Some of these programs will become redundant, while others are the critical foundations for a healthier population. For these foundational programs, county public health will likely enter into new partnerships with MCOs, employers, CBOs and some providers to promote a healthier population. Public health and countywide/targeted prevention and wellness strategies may be the most important role of future county health systems, and they may prove to be counties' most vital service to Californians' health.